# APPLICATION FOR A DENTAL HYGIENE LOCAL ANESTHETIC PERMIT

**INDIANA STATE BOARD OF DENTISTRY**
**PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
Email: pla8@pla.in.gov
www.pla.IN.gov

***Your Social Security number is requested by the agency in accordance with IC 4-1-8-1. Disclosure is mandatory and this record cannot be processed without it.**

| FOR OFFICE USE ONLY | |
|---|---|
| **APPLICATION FEE ($25.00)** | |
| **DATE FEE PAID** *(month, day, year)* | |
| **RECEIPT NUMBER** | |
| **PERMIT NUMBER** | |
| **PERMIT ISSUE DATE** *(month, day, year)* | |

**DO NOT WRITE ABOVE THIS LINE.**

| APPLICANT INFORMATION | | |
|---|---|---|
| **Name of applicant** *(last, first, middle, maiden)* | | ***Social Security number** |
| **Address** *(number and street or rural route number)* | | |
| **City** | **State** | **Zip Code** |
| **Date of Birth** *(month, day, year)* | **Place of Birth** *(city, state or country)* | |
| **Telephone Number** *(daytime)* | **Email Address** | |
| **Indiana Dental Hygiene License Number** | **Expiration Date** | |

| DENTAL HYGIENE DEGREE GRANTED BY: | | |
|---|---|---|
| **Name of School** | **Location of School** | **Date of Graduation (month, day, year)** |
| | | |

| DENTAL HYGIENE ANESTHETIC COURSE COMPLETED: | |
|---|---|
| **Name of School** | **Location:** |
| **Type of Training Received:** ☐ **Undergraduate** ☐ **Post-graduate** ☐ **Certificate** | **Date of Completion (month, day, year)** |

**EXAMINATIONS**

Check appropriate boxes indicating which local anesthesia examination you have taken:

| EXAMINATIONS TAKEN | List the number of times taken | Date of most recent examination. (month, year) | Where taken? (state or country) |
|---|---|---|---|
| ☐ **North East Regional Board (NERB)** | | | |
| ☐ **Central Regional Dental Test Service (CRDTS)** | | | |
| ☐ **Southern Regional Testing Agency (SRTA)** | | | |
| ☐ **Western Regional Examining Board (WREB)** | | | |
| ☐ **State Board Examination Which State? _____** | | | |
| ☐ **Other Examination. _____** | | | |

## STATE(S) OF LICENSURE

**Please list all states in which you have been licensed to practice any regulated Health Occupation and Registered to Administer Local Dental Anesthesia.**

| STATE | TYPE OF LICENSE, CERTIFICATE, OR REGISTRATION | NUMBER | DATE ISSUED (month, year) | DATE EXPIIRED (month, year) | CURRENT STATUS |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## EMPLOYMENT HISTORY

**List all places of employment since graduation from Dental Hygiene School. If additional space is needed, please make additional copies of this page and attach to application.**

### Employer #1

| | | | |
|---|---|---|---|
| **Name of Employer** | | **Name of Facility** | |
| **Employer Address (number and street or rural route number** | | | |
| **City** | **State** | **Zip Code** | |
| **Hours Worked Per Week** | **Dates Worked** | **From (month, day, year)** | **To (month day, year)** |
| **Employment Responsibilities: (List all responsibilities regarding this employment)** | | | |

### Employer #2

| | | | |
|---|---|---|---|
| **Name of Employer** | | **Name of Facility** | |
| **Address (number and street or rural route number** | | | |
| **City** | **State** | **Zip Code** | |
| **Hours Worked Per Week** | **Dates Worked** | **From (month, day, year)** | **To (month day, year)** |
| **Employment Responsibilities: (List all responsibilities regarding this employment)** | | | |

### Employer #3

| | | | |
|---|---|---|---|
| **Name of Employer** | | **Name of Facility** | |
| **Address (number and street or rural route number** | | | |
| **City** | **State** | **Zip Code** | |
| **Hours Worked Per Week** | **Dates Worked** | **From (month, day, year)** | **To (month day, year)** |
| **Employment Responsibilities: (List all responsibilities regarding this employment)** | | | |

| **If your answer is "Yes" to any of the following, explain fully in a signed *and* notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s), case information, detailed description of case/events and settlement amount, including court documents, if applicable. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.** | |
|---|---|
| 1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held? | ☐ Yes ☐ No |
| 2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state (including Indiana) or country, or surrendered your license? | ☐ Yes ☐ No |
| 3. Are you now being, or have you ever been treated for drug or alcohol abuse or addiction? | ☐ Yes ☐ No |
| 4. Have you ever been the subject of an investigation by a regulatory agency concerning your license? | ☐ Yes ☐ No |
| 5. Have you ever been convicted of, plead guilty or *nolo contendere* to, or are charges pending:<br>A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?<br>B. Any offense, misdemeanor or felony in any state? (Except for minor violations of traffic laws resulting in fines.) | ☐ Yes ☐ No<br>☐ Yes ☐ No |
| 6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? | ☐ Yes ☐ No |
| 7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? | ☐ Yes ☐ No |
| 8. Have you ever had a malpractice judgment against you or settled any malpractice action? | ☐ Yes ☐ No |

| **APPLICATION AFFIRMATION** | |
|---|---|
| I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct. | |
| **Signature of applicant** | **Date signed (month, day, year)** |

| **AUTHORIZATION FOR RELEASE OF INFORMATION** |
|---|
| I hereby authorized, request and direct any person, firm officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for a dental hygiene anesthetic permit.<br><br>I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.<br><br>I further authorize the Professional Licensing Agency to disclose to the aforementioned organizations, persons, and institutions from any information which is material to my application, and I hereby specifically release the Agency and Board from any and all liability in connection with such disclosure.<br><br>A photo static copy of this authorization has the same force and effect as the original. |

| **AFFIRMATION** | |
|---|---|
| I hereby swear or affirm that I have read the above statements and agree to same. | |
| **Signature of applicant** | **Date signed (month, day, year)** |